Appendix C: Procedures Regarding Service Authorization of Residential Treatment Services

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Introduction

Service authorization is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require service authorization and some require service registration.

Service Registration

Registration is a key element to the success of a care coordination model. Registering a service with Magellan of Virginia as the service is being provided ensures that the care coordinator has a complete picture of all the services an individual is receiving. Registration also may assist with identifying gaps in services that may help an individual progress in their recovery.

When registration is required, the preferred method is to log into www.MagellanofVirginia.com and follow the protocol for registering the requested service. Please note that registration is necessary for claims to be paid.

Registration is a means of notifying Magellan of Virginia that an individual will be receiving behavioral health services, avoiding duplication of services and ensuring informed care

coordination. Providers should register the start of any new service within two (2) business days of the service start date. Registration is required for Mental Health Case Management services effective December 1, 2013. Registration is required for Crisis Intervention and Crisis Stabilization Services effective April 1, 2014.

Registration may occur electronically, by phone or fax. Required elements to provide Magellan of Virginia include: (1) the individual's name and Medicaid/FAMIS identification number; (ii) the specific service to be provided, the relevant procedure code, begin date of the service, and the amount of the service that will be provided; and (iii) the provider's name and NPI, a provider contact name and phone number, and email address. The provider should also have at least a provisional behavioral health related diagnosis for the individual being served.

Claims payments will be delayed if the registration is not completed.

Service Authorizations

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS and Magellan of Virginia criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Service authorizations for Psychiatric Residential Treatment Facilities (PFTF) and Therapeutic Group Home (TGH) services are performed by Magellan of Virginia.

Service Authorization is required for the following services:

- Therapeutic Group Home Services: H2020 HW (CSA); H2020 HK (non-CSA)

- Psychiatric Residential Treatment Facility: Revenue Code 1001 (CSA); Revenue Code 1001 (non-CSA)

- EPSDT Therapeutic Group Home Services: H0019

- EPSDT Psychiatric Residential Treatment Facility: T2048 Revenue Code 0961

- EPSDT One-to-One Services: H2027

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for service authorization requests.

When a service authorization is required, follow the Magellan of Virginia's service authorization process by completing the applicable authorization request methodology [i.e., Request Higher Level of Care, Service Request Application (SRA), or Treatment Request Form]. Specifics regarding service authorization requests can be located at www.MagellanofVirginia.com.

Magellan of Virginia will approve, pend, reject, or deny all completed service authorization requests. Requests that are denied for not meeting medical criteria are automatically sent to medical staff for review. When a final disposition is reached the service authorization entity notifies the youth and the provider in writing of the status of the request.

Magellan of Virginia will make an authorization determination based upon the information provided and, if approved, will address the type of service(s), number of sessions or days authorized, and a start- and end-date for authorized services in the authorization determination;

Retrospective review will be performed when a provider is notified of a youth's retroactive eligibility for Virginia Medicaid coverage. It is the provider's responsibility to obtain service authorization for covered days prior to billing DMAS for these services. Providers must request a service authorization for retrospective review as soon as they are aware of the youth's Medicaid eligibility determination.

Once authorization is obtained, if the youth is discharged from the service and there are dates of service and units that have not been used, the provider must contact Magellan of Virginia to notify them of discharge from service so that the remaining dates or units may be available at a later date, or by another provider.

Magellan's of Virginia MIS system has edits that do not allow the same service to be authorized for different providers for the same dates. In the case where a second provider makes a request for dates that overlap, with the first provider on file, the second provider should contact the previous provider to advise that the service authorization needs to be ended. Should the second provider not be successful in obtaining release of the initial service authorization, Magellan of Virginia will then make one attempt to contact the previous provider to obtain an end date. If there is no response by the prior provider, the service authorization and the second provider's request is processed.

Providers should request a cancellation of a service authorization when there has been no service utilization within the authorized date span. Canceling a service authorization means that it never should have existed and no claims will be or have been billed against the service authorization.

If the initial period you requested is denied and the youth later meets criteria a new request may be submitted for the current dates of service as long as that request is not a retro-request for service. The new request must explain how and why they now meet criteria.

Providers are responsible to keep track of utilization of services, regardless of the number of providers. Magellan of Virginia has provided various methods for the providers to research utilization.

Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or by email to: VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.

Retro Medicaid Eligibility

Retroactive requests for authorizations will not be approved with the exception of retroactive Medicaid eligibility for the youth. When retroactive eligibility is obtained, the request for authorization must be submitted no later than 30 calendar days from the date that the youth's Medicaid was activated; if the request is submitted later than 30 calendar days from the date of activation, the request will be authorized beginning on the date it was received.

Changes in Medicaid Assignment

Service authorization decisions by Magellan of Virginia are based upon clinical review and apply only to youth enrolled in Medicaid fee-for-service on dates of service requested. Magellan of Virginia's decision does not guarantee Medicaid eligibility or fee-for-service enrollment. It is the provider's responsibility to verify the youth's eligibility and to check for MCO enrollment. For MCO enrolled youth, the provider must follow the MCO's service authorization policy and billing guidelines.

Youth Who Are Enrolled With DMAS Contracted Managed Care Organizations (MCOs)

Many Medicaid youth are enrolled with one of DMAS' contracted MCOs. In order to be reimbursed for services provided to an MCO enrolled youth that are included in the MCO contract, providers must contract with and follow their respective contract with the MCO. The MCO may utilize different service authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service youth. For detailed information, please contact the MCO directly. Additional information about the Medicaid MCO program can be found at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx. Additional

information about the CCC Plus program can be found at: http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx.

Youth who are authorized by Magellan of Virginia into PRTFs and EPSDT PRTFs will be disenrolled from the MCO as PRTF services are reimbursed for all Medicaid youth through the Medicaid fee-for-service program. TGH services and EPSDT TGH services are carved-out of the MCO contracts and are reimbursed directly through Medicaid fee-for-service. See the table below for additional information. TGH providers should contact the youth's MCO to arrange for services that are allowed to be reimbursed outside the TGH per diem and that are included in the managed care contract.

Service	In MCO Contract?	Comments
Therapeutic Group Home	No	For MCO enrolled youth, the provider must follow the DMAS coverage rules and guidelines.
EPSDT Therapeutic Group Home	No	For MCO enrolled youth, the provider must follow the DMAS coverage rules and guidelines
Psychiatric Residential Treatment Facility	No	MCO Exclusion-Disenrollment
EPSDT Psychiatric Residential Treatment Facility	No	MCO Exclusion-Disenrollment

Communication

Provider manuals are located on the DMAS website and Provider Handbooks are located on the Magellan of Virginia websites. Magellan of Virginia's website has information related to the service authorization processes for programs identified in this manual. Providers under contract with Magellan of Virginia should consult the Magellan National Provider Handbook, the Magellan Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or VAProviderQuestions@MagellanHealth.com or visit the provider website at

https://www.magellanprovider.com/MagellanProvider for additional information.

Magellan of Virginia provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the service authorization process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the Residential Treatment Services manual and the Magellan of Virginia Handbooks.

SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION/REGISTRATION

Medical Necessity Review Process Changes

Effective July 1, 2017, PRTF and TGH services began using different Medical Necessity Criteria and the IACCT review process.

Authorizations will be issued using a maximum duration of 30 calendar days per admission based on medical necessity requirements and to allow for complex care coordination in order to transition to an appropriate level of care.

The IACCT team will gather relevant information from which Magellan of Virginia will use to render a medical necessity determination. See the IACCT appendix to this manual for additional information.

The service review process used by Magellan of Virginia will assess the plan of care and treatment plan to determine if the services are adequate to treat the youth’s needs in the

PRTF or TGH setting. The Magellan of Virginia review will focus more intensively on the quality of care for the youth while in the residential service setting.

Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or by email to: VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.

Service Authorization requirements applicable to both TGHs and PRTFs:

1. Authorization shall be required and shall be conducted by Magellan of Virginia using medical necessity criteria specified in this manual.
2. Youth shall have a valid psychiatric diagnosis and meet the medical necessity criteria as defined in this manual to satisfy the criteria for admission. The diagnosis shall be current, as documented within the past 12 months. If a current diagnosis is not available, the youth will require a mental health evaluation by an LMHP, LMHP-R, LMHP-RP or LMHP-S employed or contracted with the independent certification team to establish a diagnosis, recommend and coordinate referral to the available treatment options.
3. At authorization, an initial length of stay shall be agreed upon by the youth and parent or legally authorized representative with the treating provider and the treating provider shall be responsible for evaluating and documenting evidence of treatment progress, assessing the need for ongoing out-of-home placement and obtaining authorization for continued stay.
4. Information that is required to obtain authorization for these services shall include:
    a. A completed state-designated uniform assessment instrument approved by DMAS completed no more than 30 calendar days prior to the date of submission;

    b. A certificate of need completed by an independent certification team specifying all of the following:
        i. the ambulatory care and Medicaid or FAPT-funded services available in the community do not meet the specific treatment needs of the youth;

ii. alternative community-based care was not successful;

iii. proper treatment of the youth's psychiatric condition requires services in a 24-hour supervised setting under the direction of a physician; and

iv. the services can reasonably be expected to improve the youth's condition or prevent further regression so that a more intensive level of care will not be needed;

c. Diagnosis, as defined in the most current Diagnostic Statistical Manual (DSM), and based on an evaluation by a LMHP, LMHP-R, LMHP-RP or LMHP-S completed within 30 days of admission or if the diagnosis is confirmed, in writing, by an LMHP, LMHP-R, LMHP-RP or LMHP-S after reviewing a previous evaluation completed within one year of admission;

d. A description of the youth's behavior during the seven days immediately prior to admission;

e. A description of alternate placements and CMHRS and traditional behavioral health services pursued and attempted and the outcomes of each service;

f. The youth's level of functioning and clinical stability;

g. The level of family involvement and supports available; and

h. The initial plan of care (IPOC).

5. For a continued stay authorization or a reauthorization to occur, the youth shall meet the medical necessity criteria as defined in this manual to satisfy the criteria for continuing care. The length of the authorized stay shall be determined by DMAS or its contractor. A current Comprehensive Individual Plan of Care (CIPOC) and a current (within 30 calendar days) summary of progress related to the goals and objectives of the CIPOC shall be submitted to DMAS or its contractor. The service provider shall also submit:
   a. A state uniform assessment instrument if updated since the last service authorization request;

   b. Documentation that the required services have been provided as defined in the CIPOC;

   c. Current (within the last 14 calendar days) information on progress related to the achievement of all treatment and discharge-related goals; and

   d. A description of the youth's continued impairment and treatment needs, problem behaviors, family engagement activities, community-based discharge

planning and care coordination, and need for a residential level of care.

6. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services requirements applicable to TGH and PRTFs: Service limits may be exceeded based on medical necessity for youth eligible for EPSDT. EPSDT services may involve service modalities not available to other youth, such as applied behavioral analysis and neuro-rehabilitative services. Individualized services to address specific clinical needs identified in an EPSDT screening shall require authorization by DMAS or its contractor. In unique EPSDT cases, DMAS or its contractor may authorize specialized services beyond the standard TGH or PRTF medical necessity criteria and program requirements, as medically and clinically indicated to ensure the most appropriate treatment is available to each youth. Treating service providers authorized to deliver medically necessary EPSDT services in TGHs and PRTFs on behalf of a Medicaid-enrolled youth shall adhere to the individualized interventions and evidence based progress measurement criteria described in the CIPOC and approved for reimbursement by DMAS or its contractor. All documentation, independent certification team, family engagement activity, therapeutic pass, and discharge planning requirements shall apply to cases approved as EPSDT PRTF or TGH.

7. Both initial and concurrent authorizations will be issued using a maximum duration of 30 calendar days based on medical necessity requirements and to allow for complex care coordination in order to transition to an appropriate level of care. Initial EPSDT cases will be authorized for a maximum duration of 60 calendar days based on medical necessity requirements. Concurrent EPSDT cases will be authorized for a maximum duration of 90 days based on medical necessity requirements.

8. If a youth requires acute, inpatient medical treatment (non-psychiatric), is on runaway status, or goes to detention for more than 7 days in a PRTF or 10 days in a TGH, for Medicaid purposes, the authorization will be end-dated and addressed as a discharge. Any subsequent admission to a PRTF or TGH is considered a new admission. If a youth requires acute psychiatric admission, the authorization will be end-dated and addressed as a discharge, Any subsequent admission to a PRTF or TGH would also be considered a new admission.

Note: None of the days away from the PRTF or TGH for acute medical, acute psychiatric, runaway, or detention are billable under a DMAS authorization for PRTF or TGH.

Timeliness of Submission by Providers

All initial requests for services must be submitted within one business day of admission and continued stay requests must be submitted by the requested start date. This means that if a provider is untimely submitting the request, Magellan of Virginia will review the request and make a determination from the date it was received. The days/units that were not submitted timely will be denied, and appeal rights provided.

Specific Information for Out of State Providers

Out of state providers are held to the same service authorization processing rules as in state providers and must be enrolled with Virginia Medicaid prior to submitting a request for out of state services to Magellan of Virginia. If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is encouraged to submit the request to Magellan of Virginia, as timeliness of the request will be considered in the review process. Magellan of Virginia will redirect the request back to the provider to allow the provider to become successfully enrolled.

Out of State Provider Requests

Authorization requests for certain services can be submitted by out-of-state providers of PRTF, TGH and EPSDT services in those levels of care. These specific procedures and/or services may be performed out of state only when it is determined that they cannot be performed in Virginia because it is not available or, due to capacity limitations, where the procedure and/or service cannot be performed in the necessary time period. Additional information may be found in Chapter II of this manual.

EPSDT Service Authorization Process

The EPSDT service is Medicaid's comprehensive and preventive child health program for youth under the age of 21. Federal law (42 CFR § 441.50 et seq) requires a broad range of

outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly. Examination and treatment services are provided at no cost to the youth receiving services.

Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS or its contractor as medically necessary. Therefore, services may be approved for persons under the age of 21 enrolled in Medicaid, FAMIS Plus and FAMIS Fee For Service (FFS) if the service/item is physician ordered will correct a medical condition, make it better, or prevent the child's health status from worsening.

All Medicaid, FAMIS (FFS) and FAMIS Plus services that are currently authorized by the service authorization contractor are services that can potentially be accessed by children under the age of 21. However, in addition to the traditional review, children who are initially denied services under Medicaid and FAMIS Plus require a secondary review due to the EPSDT provision. Some of these services will be approved under the already established criteria for that specific item/service and will not require a separate review under EPSDT; some service requests may be denied using specific item/service criteria and need to be reviewed under EPSDT; and some will need to be referred to DMAS. Specific information regarding the methods of submission may be found at the contractor's website, MagellanofVirginia.com

EPSDT is not a specific Medicaid program. EPSDT is distinguished only by the scope of treatment services available to children who are under the age of 21. Because EPSDT criteria (service/item is physician ordered and is medically necessary to correct, ameliorate "make better" or maintain the youth's condition) must be applied to each service that is available to EPSDT eligible children, EPSDT criteria must be applied to all service authorization reviews of Medicaid services.

EPSDT Review Process:

Individuals under 21 years of age qualify under EPSDT may receive the services described in excess of any service limit, if services are determined to be medically necessary and are prior authorized by DMAS or its contractor. A request cannot be denied as not meeting medical necessity unless it has been submitted for physician review. DMAS or its contractor must implement a process for physician review of all denied cases.